

TO HOSPITAL-ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Leonard Dewey Brookbank			2a DATE OF DEATH MONTH DAY YEAR Dec. 18, 1980			2b HOUR M					
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Apr. 29, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7a IF UNDER 1 YEAR MONTHS DAYS		7b IF UNDER 24 HRS HOURS MIN.	
7c BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7d CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.					
10 CITY OR TOWN OF DEATH Mechanicsville		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) st home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Md.						13c CITY OR TOWN St. Mary's		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS R.F.D.	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Brookbank				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Turner							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b (IF YES, GIVE WAR OR DATES)		16c SOCIAL SECURITY NO 577-12-7066		17 INFORMANT ADDRESS 4422 First St. N.E. Florence E. Brookbank, Washington, DC.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute heart failure</u> <u>4960</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cor pulmonale</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Obstructive pulmonary disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>weeks</u> <u>years</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (my hospital) attended the deceased from <u>12-18</u> 19 <u>80</u> to <u>12-18</u> 19 <u>8</u> , that (I) (we) lost the deceased alive on <u>12-18</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.)											
22b SIGNATURE <u>David L. Mossman</u> DEGREE						22c DATE SIGNED <u>12-19</u>					
22d PHYSICIAN'S NAME (TYPE OR PRINT) David L. Mossman, M.D.						22e ADDRESS Mechanicsville, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 12-21-80		23c NAME OF CEMETERY OR CREMATORY Trinity			23d LOCATION CITY OR TOWN COUNTY STATE Newport, Sharles, Md.			
24 FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.						25a DATE REC'D. BY REGISTRAR DEC 24 1980		25b REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>			

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(10)

Obituary  
for  
Dante Paul Galt  
was  
sent

12-18-1918

12-18

W. H. Galt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

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(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 8033038				
1. DECEASED NAME (TYPE OR PRINT) Langley Anthony Cullison						2a. DATE OF DEATH MONTH DAY YEAR Dec 28 1980				2b. HOUR M
3 SEX Male		4 RACE White		5 DATE OF BIRTH Oct. 8 1910		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD				
10 CITY OR TOWN OF DEATH Ridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) At home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Md State Road		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE MD						13c CITY OR TOWN St. Mary's Ridge		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Edgar Cullison						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Anthony				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS Annie M. Cocimano, Ridge MD 20680						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from Aug - 19 65, to Dec 28 19 80, that (I) (we) lost saw the deceased alive on Nov 15 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE William D. Boyd M.D.				DEGREE M.D.				22c. DATE SIGNED 12-29-80		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d PHYSICIAN'S NAME (TYPE OR PRINT) William D. Boyd M.D.				22e ADDRESS Leonardtwn, MD						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12/31/80		23c NAME OF CEMETERY OR CREMATORY St. Michael's		23d LOCATION CITY OR TOWN Ridge		COUNTY STATE St. Mary's MD		
24 FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtwn MD		25 DATE RECEIVED BY REGISTRAR DEC 31 1980		25b REGISTRAR'S SIGNATURE [Signature]		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8033039	
1- STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) James Carroll Cusic					2a. DATE OF DEATH December 30 1980			2b. HOUR M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH April 29 1908		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.					
10 CITY OR TOWN OF DEATH Hollywood		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD		13b. CITY OR TOWN St. Mary's		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS					
14 FATHER'S NAME Francis Hurley Cusic				15. MOTHER'S MAIDEN NAME Frances Laura Hall							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-32-1233		17 INFORMANT ADDRESS Getrude B. Cusic, Hollywood MD							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lupus Erythematosus</u> 6954 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-27</u> , 19 <u>80</u> , to <u>12-19</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>William D. Boyd II</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>12/31/80</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Boyd II						22e. ADDRESS Leonardtown, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 2, 1981		23c. NAME OF CEMETERY OR CREMATORY St. John's			23d. LOCATION CITY OR TOWN COUNTY STATE Hollywood St. Mary's MD			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley						ADDRESS Leonardtown, MD			25a. DATE REC'D. BY REGISTRAR JAN 5 1981		
						25b. REGISTRAR'S SIGNATURE <u>Robert M. Brady</u>					

Lupus Erythematosus

Wm. J. G. J. G.

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12/31/20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 355-1600.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 3 3 0 4 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>JAMES EDWARD DYSON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>December 28, 1980</b>		2b. HOUR <b>9:55P M</b>	
3 SEX <b>male</b>	4 RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 11 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>St. Mary's</b> MD.			
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>St. Mary's Clements</b>		13c. CITY OR TOWN <b>St. Mary's</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Dyson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Carter Dyson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>218-30-2885</b>		17. INFORMANT ADDRESS <b>Louis Dyson, Helen, MD 20635</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic Epidermoid Esophageal Carcinoma</b> <b>1509</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/17</b> 19 <b>80</b> , to <b>12/28</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>12/28</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>James C. Boyd, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type or print) <b>James C. Boyd, M.D.</b>				22e. ADDRESS <b>Leonardtwn, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/31/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Charles Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Leonardtwn MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>W. Clarke Mattingley Leonardtwn, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1981</b>		25b. REGISTRAR'S SIGNATURE <i>Richard McBrady</i>	

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 3 3 0 4 1			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Walter Cooksey Dyaon</b>				2b. HOUR MIN <b>10:20 P<sub>M</sub></b>			
3. SEX <b>Male</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 5, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's</b> MD.	
10. CITY OR TOWN OF DEATH <b>Leonardtowntown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mail Carrier</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Postal</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>St. Mary's</b>		13c. CITY OR TOWN <b>Charlotte</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lewis Gideon Dyson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Geraldine Cookaey</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>220-38-1833</b>		17. INFORMANT ADDRESS <b>Allen N. Dyson Rt. #5 Box 108 Mechanicsville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 4340 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Artherosclerotic vascular disease</b> 2 yrs. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 1979</b> to <b>DEC 25</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>12-22-80</b> 19 <b>80</b> , and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (If "we" did not last view the body after death, so state.)							
22b. SIGNATURE <b>Roy J. Guyther, M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12-26-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Roy J. Guyther, M.D.</b>		22e. ADDRESS <b>Mechanicsville, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-29-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Mem. Gardnes</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf, Charles, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Huntt Funeral Home, Waldorf, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1980</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 3 3 0 4 2			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM LEONARD FARR</b>				2a. DATE OF DEATH <b>December 11, 1980</b>		2b. HOUR <b>02:22A.</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>June 21, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>St. Mary's</b> 13c. CITY OR TOWN <b>Leonardtwn</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 2, Box 130D,</b>	
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Parran</b> LAST <b>Farr</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Martha</b> MIDDLE <b>Ellen</b> LAST <b>Davis</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-23-0359</b>		17. INFORMANT ADDRESS <b>Julia Guy Farr, same as 13e.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Lung Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 YRS</b> <b>4 YRS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/27/80</b> to <b>12/11/80</b> , that (I) (we) last saw the deceased alive on <b>12/11/80</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>William D. Boyd, II</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/11/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William D. Boyd, II M.D.</b>				22e. ADDRESS <b>Leonardtwn, Maryland 20650</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-13-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mary Queen of Peace</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Helen St. Mary's, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley, Leonardtown, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 15 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

December 11, 1944

Mr. J. Edgar Hoover

St. Mary's County

St. Mary's County

St. Mary's County

St. Mary's County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 3 3 0 4 3			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
JAMES LOUIS FENWICK				December 16, 1980			
3. SEX Male				2b. HOUR 12:02A			
4. RACE Black				5. DATE OF BIRTH Oct. 7, 1915			
6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.				7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.			
10. CITY OR TOWN OF DEATH Leonardtwn				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. St. Mary's Hollywood				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Gerald Fenwick				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Toney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No				16b. SOCIAL SECURITY NO. 214-14-2252A			
17. INFORMANT General Delivery				ADDRESS Leona J. Smallwood, Leonardtown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration Pneumonia</u> (c) <u>Cerebral Thrombosis</u>				APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Wk 1</u> <u>mo. 1</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>12/16/80</u> to <u>12/16/80</u> , that (I) (most) saw the deceased alive on <u>12/16/80</u> , and that in (my) (an) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.)							
23a. SIGNATURE J. Patrick Jarboe, M.D.				23b. DATE SIGNED 12/19/80			
23c. PHYSICIAN'S NAME (TYPE OR PRINT) J. Patrick Jarboe, M.D.				23d. ADDRESS Leonardtwn, Maryland 20650			
23e. NAME OF CEMETERY OR CREMATORY Charles Memorial Gardens				23f. LOCATION CITY OR TOWN COUNTY STATE Leonardtwn S.M. Md.			
24. FUNERAL DIRECTOR W. Clarke Mattingley, Leonardtown, Md.				25. DATE REC'D. BY REGISTRAR DEC 24 1980			
26. REGISTRAR'S SIGNATURE R. J. McCreedy							

James  
Luis  
200-100  
October 1, 1954

Dr. Mary's County

Dr. Mary's County

Dr. Mary's County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 3 3 0 4 4			
1- DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH				2b HOUR			
MARGARITE HARRIET HAWKINS				December 21, 1980				6:21 PM			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Black		Aug 1 1916		64		MONTHS		DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				St. Mary's MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Leonardtwn		St. Mary's Hospital									
13a STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS	
MD				St. Mary's		Scotland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		General Delivery	
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
Joseph				Lucinda				White Hewlett			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
no				213-22-0505		Benjamin I. Hawkins, Scotland MD					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Acute Bacterial Pneumonia</u> 5300 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Asplenia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Rheumatoid arthritis Tracheal Stenosis</u>											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>8/21</u> 19 <u>80</u> to <u>12/21</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE						DEGREE		22c DATE SIGNED			
James C. Boyd, M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12/26/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS					
Leonardtwn, Md											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial				12/27/80		St. Luke's		Scotland St. Mary's MD			
24 FUNERAL DIRECTOR NAME						24b ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
W. Clarke Mattingley Leonardtown, MD								DEC 31 1980			

10-10-64 0000 12-12-64

10-10-64 0000 12-12-64

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TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 835-1234.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE						8 0 3 3 0 4 5	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Bertha Jane/Merriman/Kelly				MONTH DAY YEAR December 7, 1980			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 1, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St Mary's MD.	
10 CITY OR TOWN OF DEATH Ridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home (Raley's House 20		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland				13b. COUNTY St Mary's		13c. CITY OR TOWN Ridge	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Rexroad				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Spiker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-24-6528		17 INFORMANT ADDRESS Harry D. Woods Ridge, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years 5.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7-17</u> , 19 <u>79</u> , to <u>12-7</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11-11</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William Boyd</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/8/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Boyd 11, M.D.				22e. ADDRESS Leonardtontown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/1980		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Maryland	
24 FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc.				ADDRESS Dundalk, Md. 21222		25a. DATE REC'D. BY REGISTRAR DEC 11 1980	
				25b. REGISTRAR'S SIGNATURE <u>John A. Bradley</u>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

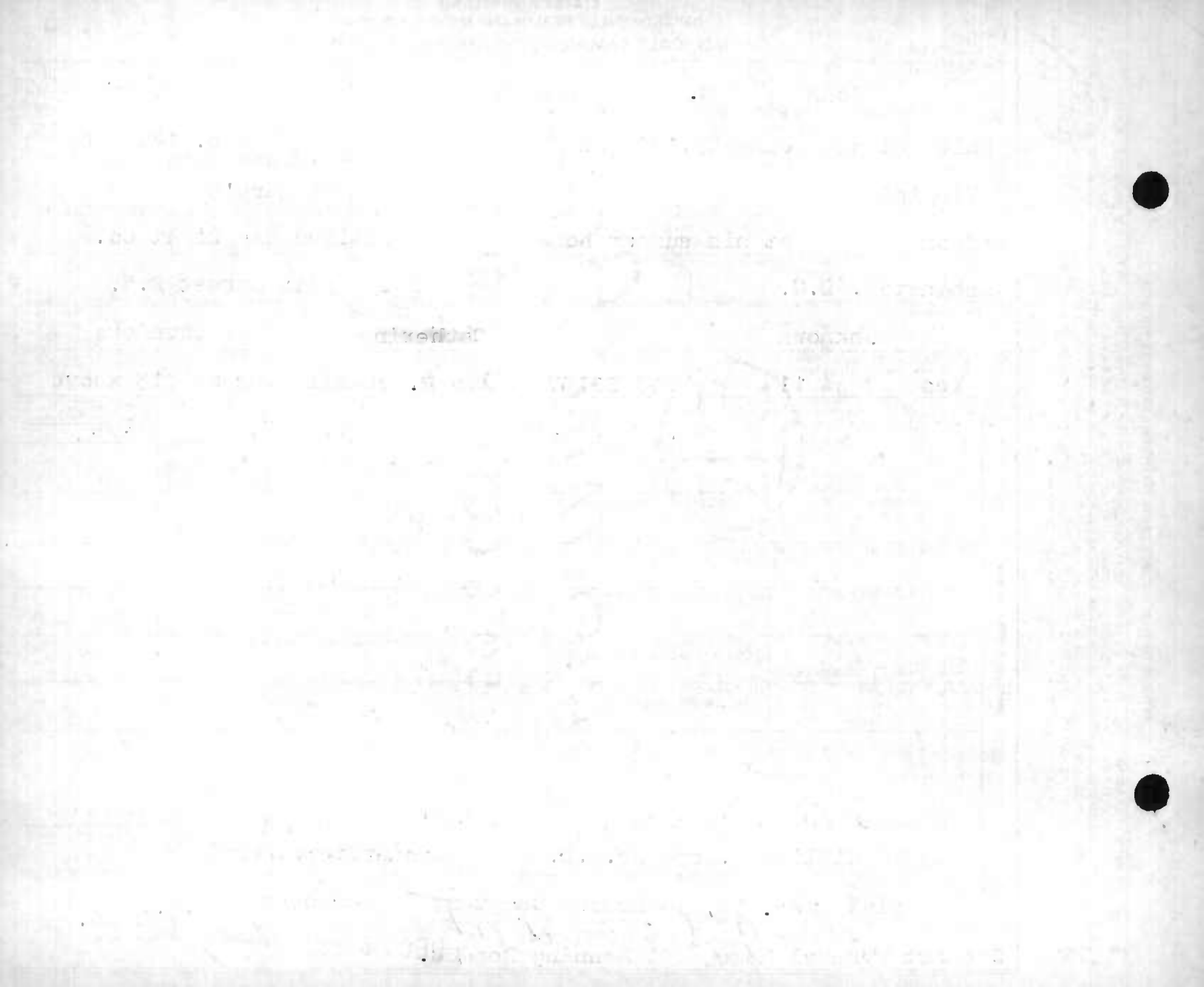
BP

DHMH - 17  
(VR A15 ME(5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR 1500M					
John E. Kendall					12-14-80			12	14	1980	1500M					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR 1500M			
Male	Black	June 29, 1918		62 YRS.				Dec. 14, 1980					1500M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Virginia	USA		WIDOWED		DIVORCED		St Mary's		MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Maddox	at his summer home				Retired Gas Light Co.											
13a. STATE												13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Washington, D.C.														YES	NO	65 54th Street S.E.
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME												
FIRST MIDDLE LAST				FIRST MIDDLE LAST												
Unknown				Catherine Saunders												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS										
Yes				WW 11		579033167 Cleo E. Kendall same as #13 above										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I DEATH WAS CAUSED BY:												IMMED.				
IMMEDIATE CAUSE (a) CARDIAC ARRYTHMIA																
DUE TO, OR AS A CONSEQUENCE OF																
(b)																
DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?				
												YES		NO		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																
ACTUAL SIGNATURE				M.D. DEPUTY MEDICAL EXAMINER				DATE SIGNED 12/15/80								
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS												
William D. Boyd Sr. M.D.				Leonardtown, Maryland												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				
Burial				Dec. 18, 1980				Harmony Cemetery				Landover P.G., Md.				
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE								
Stewart Funeral Home				DEC 26 1980				[Signature]								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 3 3 0 4 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY HARLAN KNIGHT</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>December 27, 1980</b>			
3. SEX <b>Female</b>				2b. HOUR <b>9:45</b> <b>A.</b>			
4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 18, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's</b> <b>MD.</b>	
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home maker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>St. Mary's</b> 13c. CITY OR TOWN <b>Leonardtwn</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 2, Box 39H</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>R. I. Smith</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maude Harlan</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW 2</b>		17. INFORMANT ADDRESS <b>Suzanne Gardiner Same as 13e.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 4360 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last: (b) <b>Recurrent Cerebrovascular Accidents</b> (c) <b>Cerebrovascular disease</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/12</b> 19 <b>80</b> , to <b>12/27</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>12/26</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>James C. Boyd, M.D.</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>Leonardtwn, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/31/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtwn, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1980</b>	
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

December 11, 1955

Mr. J. Edgar Hoover

St. Louis, Mo.

Dear Mr. Hoover:

I am writing you to

advise you that

the following information

Very truly yours,

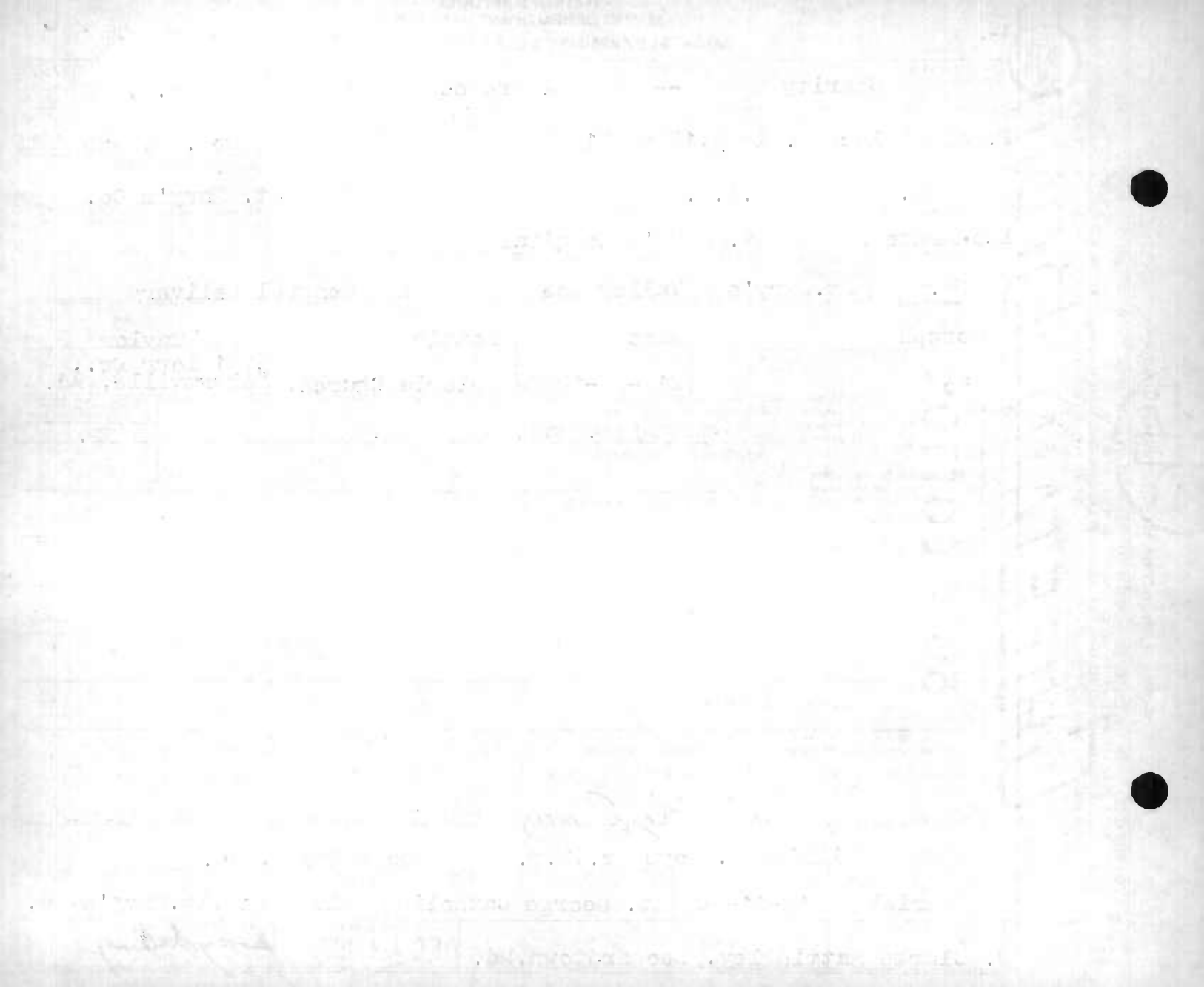
John Edgar Hoover

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 0 3 3 0 4 8			
1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		Charity			--	Lawrence		Dec. 8, 1980		12	15	1315	M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	Black	July 5, 1889		91 YRS.						Dec. 8, 1980		1315	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.		WIDOWED		DIVORCED		St. Mary's Co.		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Leonardtown		St. Mary's Hospital											
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.				St. Mary's		Valley Lee		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		General Delivery			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Joseph				Mason		Lottie				Taylor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No				216-34-1000A		Gloria Church,		2751 Lorr Dr., Forestville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:												IMMED.	
4279 IMMEDIATE CAUSE (a) CARDIAC ARRYTHMIA													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION					
								CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
William D. Boyd Sr., M.D.				DEPUTY				MEDICAL EXAMINER				12-10-80	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
William D. Boyd Sr., M.D.				Leonardtown, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				12-11-80		St. George Catholic				Valley Lee, St. Mary's, Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
W. Clarke Mattingley, Leonardtown, Md.				DEC 12 1980				Ricky McBrady					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


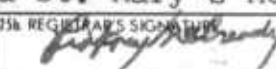
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 3 3 0 4 9 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>ALBERT LEE MATTINGLY</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>December 8, 1980</b>				2b. HOUR <b>04:15 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 16, 1897</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>00 00</b>		8. IF UNDER 24 HRS HOURS MIN. <b>04 15</b>				
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hollywood, Md.</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			12. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County</b> MD.								
13. CITY OR TOWN OF DEATH <b>Leonardtown</b>		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>						15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		16. KIND OF BUSINESS OR INDUSTRY					
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE <b>Md.</b> 17b. COUNTY <b>St. Mary's</b> 17c. CITY OR TOWN <b>Leonardtown</b>				18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19. STREET ADDRESS <b>Cedar Lane Apt.</b>									
20. FATHER'S NAME FIRST MIDDLE LAST <b>Luke W. Mattingly</b>				21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen Ivy Greenwell</b>				22. ADDRESS <b>Rt. 3, Box 649</b>							
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		24. SOCIAL SECURITY NO. <b>217-05-6354</b>		25. INFORMANT <b>William C. Mattingly</b> <b>Hollywood, Md.</b>											
26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Aneurysm</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severe Cardiovascular Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>24 hours</b> <b>10 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Virus Encephalitis with Hematomas -</b>															
27. DATE OF OPERATION		28. CONDITION FOR WHICH OPERATION WAS PERFORMED				29. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		30. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
31. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		32. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		33. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
34. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		35. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		36. LOCATION STREET CITY OR TOWN COUNTY STATE											
37. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Jan. 1947</b> to <b>Dec. 8, 1980</b> , that (I) <del>(was)</del> lost saw the deceased alive on <b>Dec. 8, 1980</b> , and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(did)</del> (did not) view the body after death.															
38. SIGNATURE <b>W.H. PATRICK JR MD</b>		39. DEGREE <b>MD</b>				40. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		41. DATE SIGNED <b>12-9-80</b>							
42. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W.H. PATRICK JR MD</b>		43. ADDRESS <b>323 MIDWAY DR LEXINGTON PARK MD</b>													
44. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		45. DATE <b>12/11/80</b>		46. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>				47. LOCATION CITY OR TOWN COUNTY STATE <b>Hollywood St. Mary's Md.</b>							
48. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley</b>				49. ADDRESS <b>Leonardtown, Md.</b>		50. DATE REC'D. BY REGISTRAR <b>DEC 12 1980</b>		51. REGISTRAR'S SIGNATURE <b>R. H. H. H.</b>							

1950 21 11 11

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 3 3 0 5 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>CATHERINE MATILDA MORGAN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>December 21, 1980</b>		2b. HOUR <b>6:45A M</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Aug. 18, 1909</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's</b> MD.	
10 CITY OR TOWN OF DEATH <b>Leonardtwn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>St. Mary's</b> 13c. CITY OR TOWN <b>Mechanicsville</b> 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				13e. STREET ADDRESS <b>Rt. 2, Box 420</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Novel Perry Hyde</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Roda Canon</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO <b>218-58-2148</b> <b>218-36-4563D</b>		17 INFORMANT ADDRESS <b>Box 428</b> <b>Dorothy L. Morgan Mechanicsville, Md.</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c): PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): _____							
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME - STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death.							
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eugene Guazzo, M.D.</b>				22e. ADDRESS <b>Chaptico, Md</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>12/23/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Morganza St. Mary's Md.</b>	
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtwn, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 26 1980</b>		25b. REGISTRAR'S SIGNATURE 	

RECEIVED 12/15/1964

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

Director, Office of the Secretary

Washington, D.C.

Dear Sir:

Enclosed for you are

three copies of

the report of the

Committee on the

State of the Union

and the report of the

Committee on the

State of the

State of the

State of the

State of the

State of the

State of the

State of the

Very truly yours,

Director, Office of the Secretary

Enclosure

Very truly yours,  
Director, Office of the Secretary

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 3 3 0 5 1			
FOR 1. STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST Warren		MIDDLE Brooke		LAST Oden Sr.		2a. DATE OF DEATH MONTH DAY YEAR December 9, 1980				2b. HOUR M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 27, 1922		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.							
10 CITY OR TOWN OF DEATH Park Hall		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Md.		13b. COUNTY St. Mary's		13c. CITY OR TOWN Park Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 57,					
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Henry Oden				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vallie Daymude									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17 INFORMANT ADDRESS Theresa M. Oden, same as 13e.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Neoplasm</u> 5396 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>3-13</u> 19 <u>80</u> , to <u>3-18</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>3-18</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)													
22b. SIGNATURE <u>William D. Boyd II.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/10/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Boyd II. M.D.				22e. ADDRESS Leonardtwn, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-12-80		23c. NAME OF CEMETERY OR CREMATORY Cheltenham Veterans				23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, P.G., Md.					
24 FUNERAL DIRECTOR W. Clarke Mattingley, ADDRESS Leonardtwn, Md.				25a. DATE REC'D. BY REGISTRAR DEC 12 1980		25b. REGISTRAR'S SIGNATURE <u>Robert M. Brady</u>							

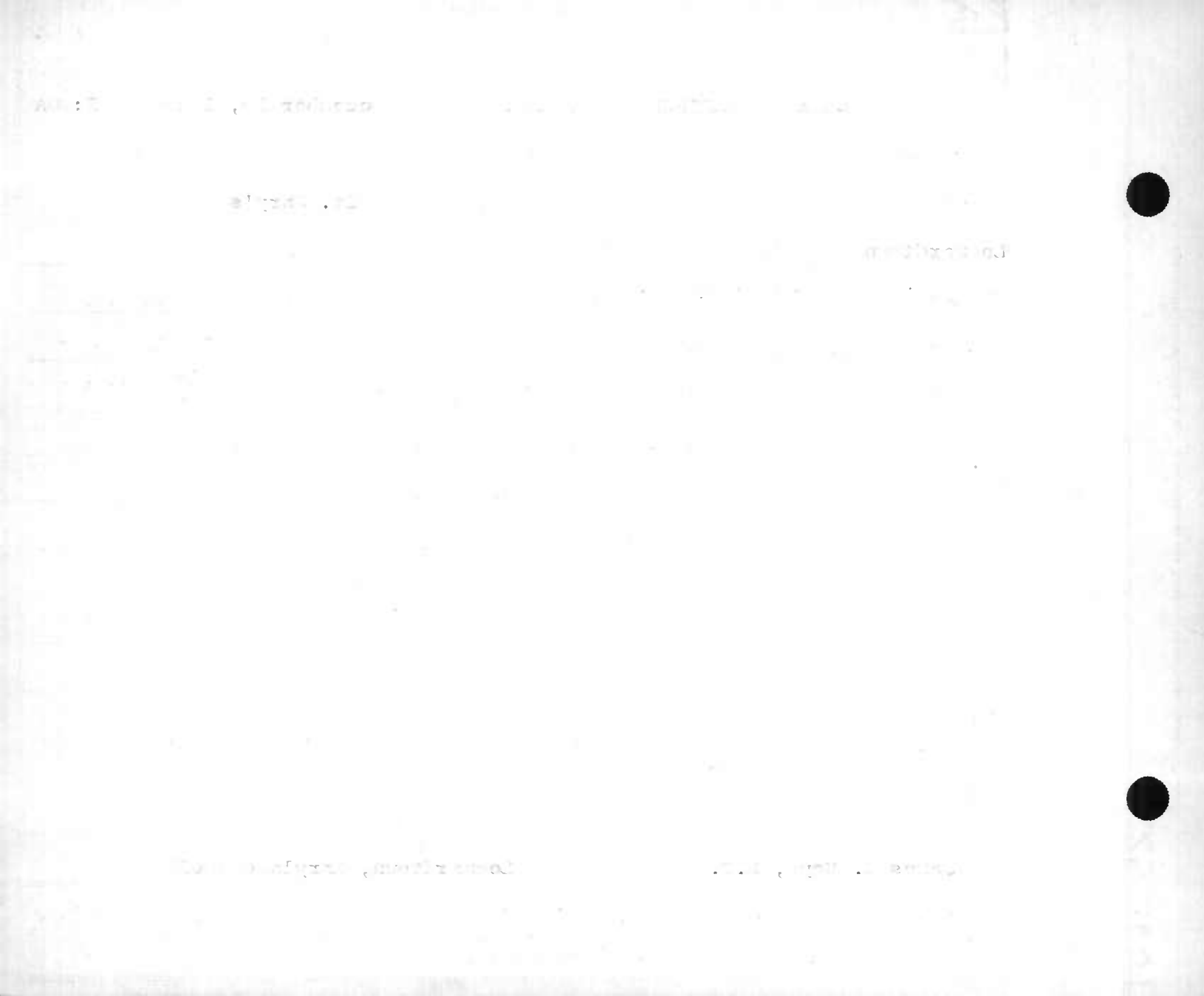
1/24/44

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 3 3 0 5 2			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>EDNA ESTHER OWENS</b>			2a DATE OF DEATH MONTH DAY YEAR <b>December 30, 1980</b>			2b HOUR <b>5:20A</b>	
3 SEX <b>Female</b>	4 RACE <b>Caucasian</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>Dec. 8, 1898</b>		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>82 YRS</b>		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Oklahoma</b>	
7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's</b> MD.			
10 CITY OR TOWN OF DEATH <b>Leonardtwn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>New Mexico</b>		13b CITY OR TOWN <b>Bernalillo Albuquerque</b>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS <b>3837 Mt. Rainier Dr. N.E.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Olin C. Berglan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Etta Mae Little</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b SOCIAL SECURITY NO. <b>564-18-5941</b>	
17 INFORMANT <b>Floyd R. Owens</b>		ADDRESS <b>3837 Mt. Rainier Dr. N.E. Albuquerque, New Mexico</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Recurrent Ventricular Tachycardia</u> 4/100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Recurrent Myocardial infarctions + Congestive Heart Failure</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>8/1/80</u> to <u>12/30/80</u> 19 <u>80</u> that (I) (we) lost saw the deceased alive on <u>12/29/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (d) did not view the body after death.							
22b SIGNATURE <i>[Signature]</i>		DEGREE <b>James C. Boyd, M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS <b>Leonardtwn, Maryland 20650</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>1-5-1981</b>		23c NAME OF CEMETERY OR CREMATORY <b>St. Michaels</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Ridge St. Mary's Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>Brinsfield Funeral Home</b>		ADDRESS <b>59 N. Washington Leonardtown, Md.</b>		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	



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DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 3 3 0 5 3			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH FRANK RALEY</b>			2a. DATE OF DEATH <b>December 9, 1980</b>		2b. HOUR <b>08:11P</b>		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 9, 1886</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>St. Mary's</b> 13c. CITY OR TOWN <b>St. Mary's</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>General Delivery</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dominic Raley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Tarleton</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-34-0801</b>		17. INFORMANT <b>Ethel H. Raley,</b> ADDRESS <b>Cedar Lane Apts. Leonardtown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>acute Myocardial Infarction</b> (c) <b>MI</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MI</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from <b>12/9/80</b> 19 <b>80</b> , to <b>12-9</b> 19 <b>80</b> , that (I) <del>was</del> last saw the deceased alive on <b>12/9</b> 19 <b>80</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> did <del>not</del> see the body after death.							
22b. SIGNATURE <b>J. Patrick Jarboe, M.D.</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12-12-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Patrick Jarboe, M.D.</b>		22e. ADDRESS <b>Leonardtwn, Maryland 20650</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-13-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Episcopal</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>St. Mary's City, S.M., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley,</b>		ADDRESS <b>Leonardtwn, Md.</b>		25. DATE REC'D BY REGISTRAR <b>DEC 15 1980</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP

11:11

Number 1, 100

11:11

11:11

11:11

St. Mary's County

St. Mary's County

St. Mary's County

St. Mary's County

St. Mary's County

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FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 3 3 0 5 4			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
ADA CATHERINE SHEGOUE				December 10, 1980				02:30AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.					
10. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.				13b. CITY OR TOWN St. Mary's Hollywood		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS Rt. 2, Box 362,			
14. FATHER'S NAME FIRST MIDDLE LAST James Goldsborough				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Farrell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-03-717204		17. INFORMANT ADDRESS 4, Eugene Franklin Shegogue, same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carcinomatous</u> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ca. of Pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>WAS mos.</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-9-80</u> to <u>12-10-80</u> , that (I) (we) last saw the deceased alive on <u>12-9-80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John E. M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-12-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Leonardtwn, Maryland</u>				22e. ADDRESS 20650							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-13-80		23c. NAME OF CEMETERY OR CREMATORY Charles Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtwn, S.M., Md.			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtwn,		25a. DATE RECEIVED BY REGISTRAR DEC 15 1980		REGISTRAR'S SIGNATURE <u>[Signature]</u>			

— 174 —

21.11.1944

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 33055	
1. FOR STATE REGISTRAR										20. DATE KNOWN OF DEATH ESTIMATED	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Lee Thomas										20. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 12 1 1980	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH (MONTH DAY YEAR) Nov. 17, 1958		6. AGE (IN YEARS) (LAST BIRTHDAY) 22 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County, MD.		21. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 1 1980		24. HOUR 8:30 PM	
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.				13b. COUNTY St. Mary's		13c. CITY OR TOWN Mechanicville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1, Box 49	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Aloysius Thomas						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Bernice Green					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-50-9416		17. INFORMANT ADDRESS Ethel B. Thomas, same as 13e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Blunt injury to head and trunk</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 7:45 P.M. 12 1 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) pedestrian struck by auto					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (ATHOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN Rt. 5 & Mechanicville-Choptico Rd. St. Mary's, MD.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER DATE SIGNED 12/2/80			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn St.				BALTO., MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-5-80		23c. NAME OF CEMETERY OR CREMATORY Charles Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtown, St. Mary's, Md.			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.						25a. DATE REC'D. BY REGISTRAR DEC 5 1980		25b. SIGNATURE [Signature]			



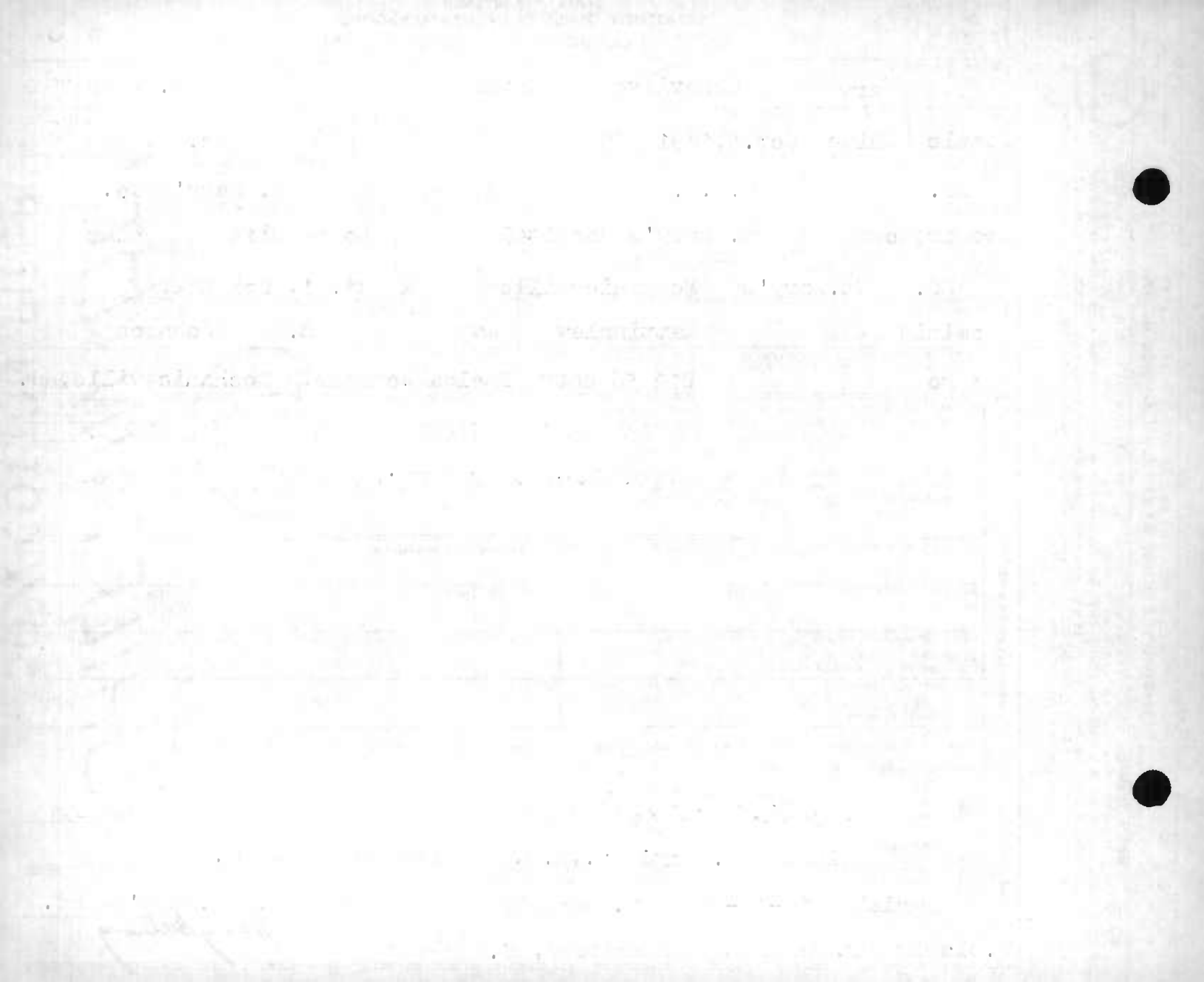
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
REG. NO. 33056											
1- STATE REGISTRAR											
1. DECEASED NAME FIRST MIDDLE LAST Mary Genevieve Wathen											
2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		8 19 80		2b. HOUR		2340 M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Female		White		Oct. 5, 1891		89					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				St. Mary's Co. MD.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Leonardtwn				St. Mary's Hospital				House wife		Home	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.		St. Mary's		Mechanicsville				Rt. 1, Box 282,			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Dominic Mattingley				May Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No				212 56 0607				Imelda Johnson, Mechanicsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) ACUTE CONGESTIVE FAILURE											
DUE TO, OR AS A CONSEQUENCE OF											
(b) ARTERIOSCLEROTIC HEART DISEASE											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMED.											
5 YEARS											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
[Signature]				M.D. DEPUTY				12-10-80			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
William D. Boyd Sr., M.D.				Leonardtwn, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				12-12-80		St. Josephs		Morganza, St. Mary's, Md.			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR	
W. Clarke Mattingley				Leonardtwn, Md.				DEC 12 1980		[Signature]	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 3 3 0 5 7 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Louis Martin Watts</b>				2a. DATE OF DEATH MONTH <b>December</b> DAY <b>29</b> YEAR <b>1980</b>				2b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>July</b> DAY <b>24</b> YEAR <b>1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8. IF UNDER 24 YRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's</b> MD					
10. CITY OR TOWN OF DEATH <b>St. Mary's City</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) <b>At home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>farmer</b>			
12b. KIND OF BUSINESS OR INDUSTRY				13a. INSIDE CITY LIMITS? <b>NO</b> <input checked="" type="checkbox"/>				13b. STREET ADDRESS			
14. FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b></b> LAST <b>Watts</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Lula</b> MIDDLE <b>Martin</b> LAST <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>219-12-2733</b>				17. INFORMANT ADDRESS <b>Mrs. James I. Waters Jr. St. Mary's</b>			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>min</b> <b>min</b> <b>hrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M.</b> <b>19</b>				21c. HOW INJURY OCCURRED. (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) <u>the hospital</u> attended the deceased from <u>10-20-80</u> to <u>12-29-80</u> , that (I) <u>last</u> saw the deceased alive on <u>12-29-80</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above. (If I <u>did not</u> view the body after death.)											
23a. SIGNATURE <b>J. Patrick Jarboe M.D.</b> DEGREE <b></b>								23b. DATE SIGNED <b>12-29-80</b>		23c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
24a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Patrick Jarboe M.D.</b>								24b. ADDRESS <b>Leonardtwn MD 20650</b>			
25a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				25b. DATE <b>1/2/81</b>		25c. NAME OF CEMETERY OR CREMATORY <b>Glen Heaven</b>		25d. LOCATION CITY OR TOWN <b>Glenn Burnie, A.A.</b> COUNTY <b></b> STATE <b>MD</b>			
26. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtwn, MD</b>				27a. DATE REC'D. BY REGISTRAR <b>DEC 31 1980</b>				27b. REGISTRAR'S SIGNATURE <b>F. J. H. H. H.</b>			

2

Handwritten signature

Dec 21 1977

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE HEALTH DEPARTMENT. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 33058	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Alexander Ferguson Wilson</b>												7a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>Dec. 12, 1980</b>	7b. HOUR A M <b>1200</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 1, 1906</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>74</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>Dec. 15, 1980</b>	1d. HOUR A M <b>1200</b>						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Utah</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St Mary's</b> MD.							
10. CITY OR TOWN OF DEATH <b>Patuxent River</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Naval Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookbinder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Calvert</b>		13c. CITY OR TOWN <b>Lusby</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>P.O. Box 236 Catalina Drive</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Wilson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth WILSON</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>217-42-4437</b>		17. INFORMANT ADDRESS <b>Cassia A. Wilson same as # 13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Cardiac Arythmia</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 yrs.</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <b>W.D. Boyd</b>				TITLE (SPECIFY) <b>Deputy</b> M.D.				MEDICAL EXAMINER			DATE SIGNED <b>12-16-80</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>William D. Boyd Sr., M.D.</b>				ADDRESS <b>Leonardtwn, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>12/18/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHRIST CHURCH CEMETERY</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>PORT REPUBLIC CALVERT MD.</b>			
24. FUNERAL DIRECTOR NAME <b>DONALD V. BORGWARDT</b> ADDRESS <b>PORT REPUBLIC, MD.</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 24 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

OHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JERRY ALLEN WITHROW			2a. DATE KNOWN OF DEATH 12 25 19 80		2b. HOUR 5:05 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH Mar. 15, 1961	6. AGE (IN YEARS) 19 YRS	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 12 25 19 80
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital (DOA)		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) VA Hwy Emp.	
12a. KIND OF BUSINESS OR INDUSTRY VA State					
13a. STATE VA					
13b. COUNTY King George		13c. CITY OR TOWN King George		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS Rt 3 Box 262					
14. FATHER'S NAME FIRST MIDDLE LAST Luther L. Withrow			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Cantrell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. XXXXXXXXXX 225/98/0772		17. INFORMANT ADDRESS same as 13 Mr. Luther L. Withrow (father)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Blunt Injury to Head</u> 8169 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <u>4:35</u> MONTH <u>12</u> DAY <u>25</u> YEAR <u>19 80</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Occupant of auto that lost control	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 243 Compton, St. Mary's, Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>		TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 12/27/80	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.		ADDRESS 111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 29 Dec. 1980		23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Owens, King George, VA		23e. DATE REC'D. BY REGISTRAR DEC 30 1980			
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR DEC 30 1980			
25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>					

